

**Prison and Probation Ombudsman  
Fatal Incidents Investigations Stakeholder Liaison Meeting**

**9 June 2011**

**Present**

Thea Walton, Prison and Probation Ombudsman's Office (PPO)  
Steve Lusted, PPO  
Susannah Eagle, PPO  
Steven McKenzie, PPO  
Rachel Gyford, PPO  
Ann Gilbert, PPO  
David Ryan-Mills, PPO  
Gordon Morrison, PPO  
Barbara Treen, National Offender Management Service (NOMS) – Women  
Debra Baldwin, NOMS – Offender Safety Rights and Responsibility (OSRR)  
Poppy Harrison, Youth Justice Board (YJB)  
Matthew Leng, Independent Advisory Panel (IAP)

**1. Apologies**

Mary Piper – OH, Trevor Brading –Serco, Sean Langley – NOMS Approved Premises, Sue Gauge – PPO

**2. Minutes of the last meeting**

Agreed

**3. Matters arising**

- a. Barbara will be copied into the quick learning bulletins
- b. Matthew reported that the recommendations from the working group on mental health have been accepted in principle following meetings in April and May. These should be ready for the next meeting in September.
- c. The quarterly clinical review stats are being collated currently
- d. Trevor will be asked to bring information on his register to the next meeting.

**4. PPO report**

Gordon circulated the report for the last three months.

***Office stats since the last meeting***

58 cases opened in prisons, 25 were natural causes and 25 were self-inflicted 8 are unclassified. 3 cases in approved premises, 1 from natural causes, 1 self-inflicted and 1 unclassified.

48 draft reports have been issued and 37 final reports circulated

62 draft reports are overdue of which one dates back to 2009 due to clinical issues and is soon to be published. 33 final reports are overdue.

From January 2011, 86 cases have been opened of which 31 are self-inflicted, 5 of those cases are young people.

Jane Webb will be leaving the office on 16 June. Robin Shone is retiring on ill health grounds on 15 June and Gordon will be leaving on 29 June. The new Ombudsman, Nigel Newcomen is expected to start in September however, he will attend SMT meetings in between and the two deputy Ombudsmen, Elizabeth Moody and Thea Walton will cover the duties between them.

The office has undertaken a strategic review over the last two months, which is a major piece of work and also reflective of the current financial situation.

The pilot work on the report presentation for a natural cause death, where death was predictable, is continuing. These reports will focus on an issues based format rather than a chronological.

A report on the death of a woman at HMP Send is due to be circulated by the end of June, this is a significant piece of work. The office is looking at deaths related to drugs particularly from poly drug use, taking non-prescribed medication and the different prescribing regimes. Lastly, issues have been raised concerning the uncertain future in deportation for prisoners. There have been instances, in some self inflicted deaths have taken place soon after receiving deportation papers and this might have been a factor.

Thea spoke on the progress of the office strategic review. There will be an increase in the research team, which we hope will strengthen to work we are able to do with our recommendations database, and help better gather stakeholder feedback. The work streams coming out of the review focus on how we can get quicker in delivering reports, whilst with fewer resources. This includes radical changes to the allocation of cases, the quality assurance of FII work. There will also be changes to the way we write report and the possibility of piloting different approaches.

## **5. OSRR**

Debra informed the meeting that the numbers of deaths was slightly up on last year and noted that the eight unclassified deaths will be classified when further information is available. There had been an apparent increase in drug related deaths from poly drug use as opposed to overdoses.

## **6. Women and young people**

Barbara reported that the women's team were working on the effect of personality disorder impacting on self-harm.

**7. High Security Estate**

No report

**8. Public Protection and Mental Health Group (Approved Premises Team)**

No report

**9. UKBA**

No report

**10. YJB**

Poppy reported that there had been the death of a young man, aged 17 years at YOI Wetherby, and that this was the first death in youth custody since November 2007. The investigation was being led by Assistant Ombudsman, Karen Johnson. Since December 2010, six people aged under 20 had died in custody, including one woman. Four of those aged over 18 who died had previously been involved with youth services and the YJB had offered its support and any required information to the PPO's investigators in these cases.

**11. IAP**

The Board has been looking at Article 2 of the ECHR investigations. Clinical reviews are also on the agenda. There is a review of the medical theories into restraint deaths and a seminar will be attended by experts on this subject. This piece of work will be updated to the Board in June and Matthew will report back at the September meeting.

**12. Offender Health**

No report

**13. Serco**

No report

**14. Presentation by PPO into two deaths of two young people**

Senior Investigator, Steven McKenzie led the meeting through his investigation into the death of one young person, just aged 18 years. The young person had been taken into care aged 4 years and his education and social skills were undeveloped. His first court appearance was at the age of 10 years and he continued to offend throughout his teenage years, for offences of robbery, violence and damage. Those offences were committed whilst he was under the influence of alcohol and Cannabis. In addition to his poor numeric and literary skills, he was also diagnosed with ADHD.

From 2008, he served three sentences at YOI Feltham. In 2010, he was sentenced to five years imprisonment and transferred from Feltham to YOI Portland. He was found with a ligature around his neck four days after his arrival at Portland. The young person did not disclose any thoughts of self harm throughout his time in custody.

Discussion was led on the role of his YOT worker and mentor, whom he had a good relationship with. Those roles were withdrawn when he became 18 years old. He was also concerned that Portland was along way from his family and for them to visit him.

Mr McKenzie also reported that similar circumstances in life and family background of this case, was evident in his second investigation of the self inflicted death of a young man, again just 18 years old, in December 2010.

The meeting talked around the issues raised in both cases, the offending behaviour of both these young men being raised in an unstable and chaotic family life, with poor education attainment and substance misuse. Prison regime, population management, and challenges in providing appropriate mental health services, were further discussed.

#### **15. Research**

David was asked to offer information on potential research and told the meeting that there are two potential areas being considered. One was the reception process and the second on bullying and intimidation. The latter will be subject to further exploration in the coming months.

#### **16. Date of the next meeting**

The next meeting will be on 8 September at 2pm, and focus on drug related deaths